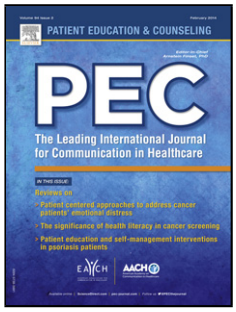

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Consensus statement on an updated core communication curriculum for UK undergraduate medical education

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Abstract

Objectives

Clinical communication is a core component of undergraduate medical training. A consensus statement on the essential elements of the communication curriculum was co-produced in 2008 by the communication leads of UK medical schools. This paper discusses the relational, contextual and technological changes which have

affected clinical communication since then and presents an updated curriculum for communication in undergraduate medicine.

Method

The consensus was developed through an iterative consultation process with the communication leads who represent their medical schools on the UK Council of Clinical Communication in Undergraduate Medical Education.

Results

The **updated** curriculum defines the underpinning values, core components and skills required within the context of contemporary medical care. It incorporates the evolving relational issues associated with the more prominent role of the patient in the consultation, reflected through legal precedent and changing societal expectations. The impact on clinical communication of the increased focus on patient safety, the professional duty of candour and digital medicine are discussed.

Conclusion

Changes in the way medicine is practised should lead rapidly to adjustments to the content of curricula.

Practice Implications

The **updated** curriculum provides a model of best practice to help medical schools develop their teaching and argue for resources.

1. Introduction

Clinical communication was introduced into the undergraduate medical curriculum in the 1990s and has become a standard component in all medical courses in the UK, and increasingly, across the world. In 2008 a consensus statement, reached by an iterative consultative process involving **representation from** all **33** UK medical schools, crystallised the core curriculum for clinical communication for

undergraduate medical education [1]. Its purpose was to help teachers to develop their curricula and to have a model of best practice with which to prepare their students for conducting effective, professional and sensitive conversations with patients, relatives and colleagues.

It may seem unlikely that communication teaching should change; unlike our colleagues at the cutting edge of genetic science, we may feel we are dealing with eternal verities about human interactions which surely cannot vary much in a decade. However medical care does change, expectations of medical care alter and doctors' communication must inevitably follow suit. Curricula within medical education must consequently adapt to ensure that students are well prepared for their future practice [2,3].

The drivers of change affecting the clinical communication curriculum can be categorised as:

- Relational
- Contextual
- Technological

Some relate to new emphases and some to entirely new areas of teaching and learning.

The relationship between the doctor and patient has always been a focus of clinical communication teaching, with an emphasis on patient-centred care and supporting patient autonomy. The concept of shared decision making, which has been elaborated in an extensive literature since the last consensus statement, was recently brought to the fore by a legal precedent arising from a Supreme Court ruling. This concerned the information given to a pregnant patient with diabetes about birth options and their likely benefits and risks [4]. As a consequence of the

ruling, which was decided in favour of the patient, consent is now judged on the basis of what a *reasonable patient wants to know*, not what a *reasonable doctor wants to say* [5]. This has overturned long-held beliefs about which member of the doctor-patient dyad is the final arbiter of whether communication has been effective. The doctor's role reflects societal expectations of those with the skills and knowledge to provide medical care and thus is constantly evolving [6]. The previously radical idea that the doctor and the patient are *both experts in their own areas of experience* [7] has paved the way for an understanding that healthcare decisions are best made collaboratively with the people who have to live with the consequences of those decisions. This was reflected in the UK Government's White Paper in 2010, which emphasised that shared decision making would become the norm in medical care and that patients could expect *'no decision about me without me'* [8]. The notion that the doctor's role is to support the patient in developing an *informed preference* on which to base their decision [9] is gradually replacing the convention that the doctor provides advice with which patient is simply expected to 'comply'. The central role of patients in making decisions about their own healthcare continues to be emphasised in UK national guidance [10] albeit sometimes as a consequence of litigation [11]. An awareness of how the doctor-patient relationship continues to change over time is essential to help students navigate the landscape within which they will practise throughout their careers.

Whilst *patient-centred care* is the philosophy underpinning medical practice in the UK, in reality students are exposed to a variety of models of the doctor-patient relationship. These vary in the extent to which the patient's perspective, autonomy, emotions and individual circumstances are taken into account. This variety of approaches often reflects generational and cultural differences in how students'

supervisors were taught, and does not necessarily reflect the standards upon which current graduates will be judged. In order to learn effective approaches to communicating with and supporting patients, students need role-modelling by clinicians which reflects modern standards of care, as well as classroom-based teaching and practice.

Even within the last decade, the language used to describe the doctor-patient relationship has changed. Many publications no longer use the word 'patient' when describing a person who uses healthcare services or lives with a long-term medical condition [12-14]. Just as the term 'patient-centred' is becoming more widely understood, it is giving way to the term 'person-centred'. Medical teachers no longer recommend strategies for students to 'deal with emotional patients' or suggest 'allowing the patient to talk' but will refer to 'responding to the patient's emotions' or 'enabling the patient's contribution'. Similarly the labelling of patients (e.g. as 'difficult' or 'heartsink') is rightly viewed as disrespectful and fails to encourage doctors to take responsibility for communicating effectively in situations they find challenging. The use of language demonstrates the expectation that people receiving healthcare are treated with respect and as people rather than as 'diseased bodies' or a source of problems. This challenges the appropriateness of the traditional discourse of a 'passive patient', which is represented by terms still commonly used, such as *'taking a history'*, '*consenting a patient'* and *'compliance with treatment'*.

Despite widespread teaching of the core elements of effective communication, reports continue to appear where doctors:

- fail to introduce themselves or to look at the patient when delivering bad news [15]

- talk about patients as if they were not there [16]
- communicate poorly and show lack of respect [17].

Whilst the causes of these problems are likely to be many and varied, the underlying discrepancy between what people *expect* from medical care and what they *receive* points to a need for healthcare professionals to take communication as seriously as patients do. Any communication curriculum must take into account what patients want (Table 1) [18]. This is becoming an increasing focus of research, with studies noting the importance patients place on the relationship with the doctor, and specifically the doctor's ability to listen, empathise and provide care tailored to the individual [19].

*** Table 1 about here ***

Since the consensus statement was published in 2008, the role of professionalism has been highlighted by a public inquiry in the UK, which emphasised the need to improve standards of care, enhance interprofessional communication and learn lessons from corporate and individual mistakes [20]. This also prompted an increased focus on responding effectively to patients and families affected by medical error, resulting in a new *statutory duty of candour* [21]. The concept of professional behaviour as a taught subject is being increasingly adopted in medical education, incorporating elements of interpersonal skills, working group norms and organisational culture [22]. Lessons learned from analysing adverse events have given considerable impetus to the issue of patient safety. Subsequent directives have been published by national and international bodies providing guidance to professionals who need to raise concerns about patient care [23,24].

In parallel, there has been an increased focus on the explicit teaching of clinical reasoning in addition to clinical communication in some medical schools [25-27]. Inadequate gathering and processing of information have been found to be responsible for many diagnostic errors [28,29]. The interplay between clinical knowledge, reasoning and communication in effectively assessing a patient's problems is being emphasised in many curricula.

These new emphases on professionalism, patient safety and clinical reasoning have implications for clinical communication teaching. An upsurge in simulation-based training has been evident, focusing not only on communication with patients and relatives, but including key events relating to patient safety, such as handover to colleagues [30,31].

Technological changes over the past decade include the growth of telemedicine and skills needed to consult safely and effectively by electronic means, such as video-conferencing. In the UK, most interactions in clinical practice and communication teaching are face-to-face, which leaves many graduates ill-prepared to provide care via other media. Technology also presents challenges in traditional consultations. Although some doctors have been using electronic health records for over a decade, the interactional skills needed for this triadic (patient-doctor-computer) consultation have received little attention [32]. This is becoming a priority, as services across the spectrum of primary, secondary and tertiary care switch to the use of electronic health records in every patient consultation. Whilst it might be expected that learners who are 'digital natives' will simply incorporate technology seamlessly into their practice, evidence suggests that students need guidance and role modelling in the use of electronic health records [32,33]. Students themselves are aware of the impact of technology on the quality of their interactions with patients [33].

As technological advances facilitate remote monitoring of patients' physiological data (for example, in the management of long term conditions) the nature and frequency of interactions between doctors and patients is changing. This is amplified by the expansion of multi-disciplinary teams, the increase in patient contacts with team members from other disciplinary backgrounds and a reduction in continuity of the doctor-patient relationship over time [34]. **Advances such as precision medicine, which aims to provide targeted care based on the individual patient's genetic make-up, health, lifestyle and environment, have implications for topics discussed in the doctor-patient consultation, as well as the collection and use of patient data [35].**

The combined impact of these relational, contextual and technological changes has had a profound effect on doctor-patient communication in practice over the past decade, prompting a revision of the curriculum. This article presents an updated curriculum for clinical communication in undergraduate medicine. This consensus statement has been developed by the UK Council of Clinical Communication in Undergraduate Medical Education, an organisation comprised of the clinical communication leads in **all 33** UK medical schools.

2. Methods

As with the original consensus statement, the **revised** curriculum has been developed through an iterative process of discussion with the leads for clinical communication teaching from all UK medical schools, who represent their schools on the UK Council. The purpose of the consensus statement remains identical, in that it aims to assist curriculum planners in the design of clinical communication curricula for medical students.

A sub-group of representatives **from several medical schools volunteered** to co-ordinate work on the consensus statement. Consultation was conducted with the whole UK Council at three national meetings (**in London, York and Leicester** from April 2016 to March 2017). **The UK Council holds a one-day meeting every six months, attended by one to two leads for clinical communication teaching from each medical school. At the three meetings, small group and plenary sessions were conducted to discuss the original consensus statement, changes in medical practice with implications for communication teaching, new topics and changes needed to the content and format of the curriculum.** Through this process, particular issues relating to clinical communication teaching were identified that have changed sufficiently to require updating in the consensus statement. **A core sub-group of representatives from four medical schools co-ordinated the consultation process and prepared the updated consensus statement.**

3. Results

The curriculum wheel

The original curriculum was represented by a 'wheel', which aimed to present the entire curriculum in an easily accessible form. The consensus from the consultation, based on the experiences of those who had used the original curriculum and the perspective of newer members, was that this diagrammatic representation was helpful. It was agreed that the format would be retained, whilst updating certain elements (Figure 1).

Figure 1 about here

Core components of communication are represented by the inner circles of the wheel. Outer rings represent specific issues in communication, methods of communication and communication with those other than the patient. The curriculum is underpinned by a set of principles which govern all medical practice, presented as the context surrounding the wheel.

The wheel is designed such that the rings can be rotated independently, in order to 'dial a curriculum'. For instance, a curriculum planner may design a session for students to practise gathering information with a patient who speaks little English via an interpreter over the phone or a session to practise explaining a medical error to a relative face-to-face.

Key principles underpinning clinical communication teaching

The core value of respect for others remains at the centre of the curriculum. Respect is key to all interactions with patients, relatives, colleagues and others involved in patient care. It is the first building block for developing effective partnerships and is essential in supporting and enabling the patient's role in their own healthcare. **In addition, students need a core knowledge base for clinical communication: an appreciation of conceptual frameworks and research evidence, which** includes:

- evidence about effective doctor-patient communication and the relationship between communication and patient satisfaction, recall and healthcare outcomes [36,37]
- conceptual frameworks and philosophies of care (such as patient-centredness)
- models of the doctor-patient relationship and the consultation

- approaches to supporting patients at different stages of care [38].

A new addition to the underpinning principles is the explicit role of practice in the development of an individual's understanding of, and skills in, clinical communication. Practice refers to:

- the way in which students integrate concepts (such as 'respect' or 'patient-centred care') into their clinical interactions
- the refinement of skills through repetition [39].

Core components of clinical communication

The Calgary-Cambridge Guide to the Medical Interview [36], which is widely used in UK medical schools, informed the core components in the original curriculum. This framework sets out the fundamental building blocks of the consultation in four sequential stages:

- Initiating the consultation
- Gathering information
- Explanation and planning
- Closing the consultation

These are supported by two parallel tasks throughout the consultation:

- Building the relationship
- Providing structure

These core components have been retained in the updated curriculum. Shared decision making has been added to the 'explanation' task of the consultation. In 2008, the task of 'explanation and planning' included:

- **the content to be addressed: e.g. explaining relevant diagnoses, planning and negotiating**

- **process skills: such as determining the patient's starting point, 'chunking' information and checking understanding**

The process of shared decision making actively involves the patient as a stakeholder in their own healthcare. This includes a number of additional elements [40-42], such as:

- **clarifying goals for treatment**
- **sharing information about available treatment options, including the option of taking no treatment**
- **discussing information about the potential benefits and harms of the treatment options, including any uncertainties**
- **discussing preferred outcomes**
- **clarifying the patient's values (what matters most to the patient)**
- **supporting the patient in deliberating**
- **documenting and implementing the patient's choice**

This process includes core skills in sharing information effectively, communicating about risk, responding to patients' emotions and concerns, and working in partnership.

Specific domains of communication

The core components provide a secure platform upon which doctors can build their consultations. Beyond these, there are specific areas of communication which are known to be challenging for doctors, and which warrant particular attention in teaching. Some of these domains focus on the skills and approaches that students need in order to have compassionate and effective conversations under more challenging circumstances. These include:

- Discussing sensitive issues, e.g. difficult, embarrassing and stigmatised topics, such as death, dying, bereavement, sex, mental illness, abortion, addiction, domestic violence and child abuse.
- Responding to emotions, e.g. distress, fear and anger, as well as understanding and responding to the emotional impact of illness on the patient and their family.
- Responding to uncertainty: about diagnosis, prognosis and establishing the 'correct' treatment option for the patient to meet their needs.
- Discussing mistakes and complaints: disclosing medical error (caused by the doctor personally or a team member) to patients and families; responding to those who wish to complain about their care.

Whilst these domains were included the previous curriculum, the language has changed (previously 'handling emotions', 'handling mistakes and complaints' and 'dealing with uncertainty').

Specific domains which have changed are:

- Breaking bad news. **Originally included under the domain of 'sensitive issues', this has been explicitly added to the wheel in the revised curriculum. This includes sharing difficult news and discussing with patients and those close to them:**

- diagnosis and prognosis, e.g. when the condition is serious, long-term, life-changing or life-limiting

- treatment, e.g. there are no effective treatments, there is a risk of serious adverse effects, treatment is no longer effective, transfer to palliative care, 'do not attempt resuscitation' decisions

The specific domains also encompass the duty of doctors to provide equitable care which meets every patient's needs according to their individual circumstances. This includes:

- Diversity in communication. The term diversity refers to individual differences among people: due to age, nationality, physical ability or impairment, ethnic or cultural background, sexual orientation, religious beliefs, learning ability or difficulties, socio-economic status, education, communicative ability and family background. **This merges two domains from the previous curriculum ('age-specific' and 'cultural and social diversity') whilst expanding the remit to include the expectation that students will be able to communicate effectively with all patients, regardless of background, personal characteristics or world view.**

- Barriers to communication. This includes navigating specific communication barriers, which may be due to language, cognitive or hearing impairments, or physical or learning disabilities [43].

The domains also include communication in different types of consultations:

- Specific clinical contexts. For example, the exigencies of emergency medicine may emphasise the skills of rapid diagnosis, multi-tasking, co-ordination and teamwork, or responding to aggression. Particular clinical topics, such as alcohol and substance misuse, may be addressed in a consultation differently depending on the clinical setting (e.g. general practice, emergency department, substance misuse clinic).

- Health behaviour change. This includes the skills required to support behavioural change and enable people to manage their long-term conditions. **This replaces a domain ('specific application of explanation') from the previous curriculum.**

- Communication during procedures. **A new addition, this includes communication whilst the patient is undergoing practical procedures to:**

- explain the proposed procedure

- ensure that the patient has agreed to the procedure before proceeding

- respond effectively to patient questions, concerns and emotions

- provide an appropriate commentary

This should encompass a variety of procedures, including those that are more invasive (such as taking blood and catheterisation).

Methods of communicating

Whilst commonly used methods addressed in teaching include face-to-face, telephone and written communication, the updated curriculum specifically mentions digital medicine and the electronic health record. These include skills in:

- **conducting an effective consultation whilst managing the 'third party' presence of the computer**
- **using a variety of electronic methods of communication (including email, video conferencing and remote transmission of data) to co-ordinate, deliver and document patient care**
- **evaluating the impact of changing methods of care in the digital age on communication with patients, relatives and colleagues**

Communication beyond the patient

The curriculum also includes communication *about patients,* which encompasses working effectively with relatives, interpreters, advocates and carers, as well as colleagues both within and outside medicine. This includes skills in:

- conducting a 'triadic' consultation (e.g. patient-relative-doctor)

- decision making consultations involving those close to the patient
- working with lay and professional interpreters
- communication with colleagues through a variety of media

In the updated curriculum, 'team-working' has also been added, which includes skills in:

- **working within and leading multi-disciplinary teams**
- **using structured approaches to presenting patient cases and handover**
- **raising concerns**

Supporting principles

The entire communication curriculum is sited in a context of a set of principles which govern all areas of medical practice: professionalism, ethical and legal principles, evidence-based practice and reflective practice. Two further domains have been added: patient safety and clinical knowledge and reasoning. This highlights the expectation that students will have an appreciation of:

- **the role of communication in increasing or decreasing the risk of medical error**
- **communication strategies and tools to promote patient safety (e.g. the World Health Organisation Surgical Safety Checklist)**
- **biases in clinical reasoning affecting the consultation which lead to diagnostic errors**

4. Discussion and Conclusion

4.1 Discussion

The updated curriculum highlights some important changes, as well as emphasising elements which continue to need reinforcement in teaching.

The core value of respect has been highlighted by recent reports and policy initiatives [20,44] as well as by research examining what elements of communication are important to patients. It underpins the expectation that doctors will communicate effectively and sensitively regardless of the patient's age, social, cultural or ethnic background, disabilities or language [45,46]. Nonetheless, poor communication and lack of respect are still consistently found to be highly prevalent in complaints against doctors [17]. This signals a need to continue to explicitly address the requirement for respectful communication in medical teaching.

Effective communication involves a combination of values, knowledge and behavioural skills. Learning models increasingly recognise the role of practice in embedding complex learning over time [47,48]. As well as learning a repertoire of skills and approaches, students learn, through repeated practice, how to make decisions about what is required in different situations and how to enact their plans as part of a genuine dialogue. A learner's understanding of 'patient-centred care', for example, is not complete without the experience of delivering this care.

Many of the essential tasks of the consultation (for example, to agree an agenda, build a partnership, exchange information, use time efficiently and agree a plan) have not changed in the past decade. However, the increased focus on patient autonomy has highlighted the importance of explicitly signalling the task of *shared decision making*. Medical schools must prepare students to enable effective patient participation in decisions about care [8,10,40] **to ensure that graduates can deliver care that meets the standard set by legal precedent [4].**

The active participation of the patient in discussions about their own health and treatment is set to be amplified by advances in medical care. In precision medicine, for example, interventions are uniquely targeted towards the individual patient's genetics, circumstances and needs. This has new implications for information provision, risk communication, supporting patient choice and coping with uncertainty, which teaching must address.

Doctors will always need to be able to conduct sensitive and compassionate conversations with patients and those close to them about difficult subjects. This includes appreciating the emotional impact of illness on families, navigating healthcare decisions when the 'best' course of action is not clear, and maintaining honest and respectful relationships when things go wrong. Recent policy changes **have served to emphasise the rights of patients and relatives in these situations** [21]**, which must be reflected in communication teaching. Specifically, breaking bad news has been given new prominence in the updated curriculum. Recent evidence shows that doctors continue to struggle with discussing bad news with patients and relatives, across a range of situations [15,49-51]. The impact of these conversations is profound for patients and relatives. We must ensure that our graduates can provide supportive and compassionate care when it is most needed.**

Other specific domains in the revised curriculum explicitly emphasise the duty of doctors to provide equitable care, as the role of equality, diversity and inclusion in healthcare communication has been increasingly recognised [52]. Educational programmes that encourage students and faculty to adopt an openness to exploring their own cultural beliefs and practices, as well as those of patients have been proposed [53]. Students also need to be equipped to navigate specific

communication barriers, to ensure that patients with any form of disability are not disadvantaged (including through a lack of communication support), in accordance with the law [54].

The need to take account of the setting, clinical scenario and specific needs of the patient has always been present in the communication curriculum. Increased emphasis has been given to equipping students to support behavioural change and enable people to manage their long-term conditions [55]. This reflects the trend to include health promotion and preventive medicine as a routine component of health care consultations [56], with the aim of using the opportunity afforded in individual healthcare encounters to improve population health. **As the number of patients with long-term, complex conditions requiring self-management continues to increase, graduates will need effective consultation skills to support patients with these needs [34].**

The addition of communicating during procedures to our model signals the explicit attention now being paid to the integration of practical and communication skills at undergraduate level [57]. It also reflects the increasing practice of siting communication skills teaching within an authentic clinical environment to overcome the potential theory/practice gap [58].

The rapid expansion of electronic methods of communication in healthcare has raised concerns that electronic templates may override the patient narrative in the context of long-term condition management [59, 60]. This, along with the challenge of how to manage the interactional process of the consultation with the additional 'third party' presence of the computer [61], are key in the ongoing development of curricula [32,34]. **Our graduates will need to develop competence in communicating effectively delivering new services and using innovative**

technologies, which they may not encounter in routine clinical practice whilst at medical school. This highlights the need for communication teaching to be forward-looking and to prepare students for lifelong learning.

In the broader context, lessons learned from devastating failures of care and known sources of error have emphasised the role of clinical reasoning and team-working competencies in safe and effective practice **[20,28,29,**62]. **This highlights the need for integrated teaching and 'joined up' thinking.**

In the past ten years, there have been subtle but important changes in the use of language. Language plays a key role in the framing of the doctor-patient relationship and signalling to students that the patient is an equal partner and stakeholder in the consultation. Language of course continues to evolve; perhaps by the time the curriculum is updated again, 'patient' will be replaced by 'person'.

4.2 Conclusion

Expectations of the relationship between the doctor and patient have changed over the past decade. This has necessarily altered how doctors interact with, and talk about, patients. The required standard of doctors' communication is inextricably linked to expectations of medical care, which reflects cultural changes in society, evolving professional guidance, legal precedent and lessons learned from failures in care. In many ways, the focus of clinical communication teaching has not changed: students must learn to listen, question, explain and offer support in a way which respects patients and their right to make decisions about their own care. Nonetheless, the communication curriculum must remain responsive to contextual changes which can fundamentally affect clinical communication. Students must be

prepared to support patients in navigating complex decisions, provide honest explanations of errors and consult effectively in an age of digital medicine. Communication is at the heart of medical care, and consequently students require comprehensive preparation in order to best care for patients throughout their medical careers. The updated clinical communication curriculum provides a model of 'best practice' which medical schools can use to develop their teaching and to argue for resources.

This paper is intended to help curriculum planners consider what might need updating in their undergraduate courses. It is aspirational and not all schools in the UK are yet addressing all the changes that have been outlined here. Nevertheless, this is the consensus reached by UK medical schools about how to prepare our students to meet the demands of delivering effective, compassionate and contemporary patient-centred care.

4.3 Practice implications

Curriculum time is precious and resources are finite. The aim of the original consensus statement was to share best practice and encourage curriculum development, without being prescriptive about when, where or how much teaching would be delivered. In the history of medical education, clinical communication is a relatively new subject, and it has been incorporated by medical schools in different ways. Yet it has developed rapidly, in many schools starting with small amounts of isolated teaching and expanding across years, clinical disciplines and assessments. Curriculum planners may wish to use the updated consensus to review the content of current teaching, develop new sessions, devise sessions integrating communication with other topics, or a combination of these. Experienced clinical communication educators will be aware that teaching is most effective when

students have the opportunity to practise and reflect, is repeated (rather than a one-off), and is integrated into the fabric (and assessments) of the medical course [38,63-67].

The impact of role-modelling, especially on clinical attachments, requires particular attention to ensure congruence between taught and observed practice. Clinical staff can be supported in reinforcing communication learning by being involved in the medical course, workplace-based assessments and formal examinations. Whilst medical schools often have a champion (or even a small team) leading the communication curriculum, supporting students in becoming effective medical communicators is a responsibility shared across the whole medical school.

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References

[1] M. von Fragstein, J. Silverman, A. Cushing, S. Quilligan, H. Salisbury, C. Wiskin, UK consensus statement on the content of communication curricula in undergraduate medical education, Med Educ. 42 (2008) 1100-7.

[2] G.M. Stirrat, C. Johnston, R. Gillon, K. Boyd, Medical ethics and law for doctors of tomorrow: the 1998 Consensus Statement updated, J Med Ethics. 36 (2010) 55-60.

[3] General Medical Council, Updating our expectations of newly qualified doctors in the UK: reviewing the outcomes for graduates, 2017. https://www.gmc-uk.org/education/31336.asp (accessed 15 November 2017)

[4] Montgomery v. Lanarkshire Health Board, UKSC 11, 2015.

[5] J. de Bono, Thefaut v. Johnston (2017): a game changer for consent in elective surgery, Bone and Joint 360. 6 (2017) 41-3.

[6] A. Cushing, History of the doctor-patient relationship, in: J. Brown, L.M. Noble, A. Papageorgiou, J. Kidd (Eds.), Clinical communication in medicine, John Wiley and Sons, Chichester, 2016, pp. 6-20.

[7] D. Tuckett, M. Boulton, C. Olson, A. Williams, Meetings between experts, Tavistock Publications, London and New York, 1985.

[8] Department of Health. Equity and excellence: liberating the NHS (White Paper), The Stationery Office, London, 2010.

[9] G. Elwyn G, Shared decision making made easier: tools for the trade, AACH American Academy on Communication in Healthcare webinar, 4 October 2016.

[10] NICE National Institute for Health and Care Excellence, Putting patients, excellence and experience at the heart of care, 11 March 2016. http://www.nice.org.uk/news/article/putting-patients-excellence-and-experience-at-the-heart-of-care (accessed 15 November 2017).

[11] Royal College of Surgeons, Consent: supported decision making. A guide to good practice, Royal College of Surgeons, London, 2016.

[12] N. Ahmad, J. Ellins, H. Krelle, M. Lawrie, Person-centred care: from ideas to action, The Health Foundation, London, 2014.

[13] All-party Parliamentary Group on Women's Health, Informed choice? Giving women control of their healthcare, House of Commons, London, 2017.

[14] Health Education England, Skills for Health, and Skill for Care, Person-centred approaches: empowering people in their lives and communities to enable an upgrade in prevention, wellbeing, health, care and support. A core skills education and training framework. Skills for Health, Bristol, 2017.

[15] K. Granger, Hello my name is: introduction, 2014. http://hellomynameis.org.uk/home (accessed 15 November 2017).

[16] Care Quality Commission, NHS Patient Survey programme: 2015 Adult inpatient survey: statistical release. Care Quality Commission, Newcastle upon Tyne, 2016.

[17] General Medical Council, The state of medical education and practice in the UK 2012, General Medical Council, London, 2012.

[18] G. Makoul, E. Krupat, C.H. Chang, Measuring patient views of physician communication skills: development and testing of the Communication Assessment Tool, Patient Educ Couns. 67 (2007) 333-42.

[19] J. Bensing, M. Rimondini, A. Visser, What patients want, Patient Educ Couns. 90 (2013) 287-90.

[20] The Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis, QC, Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 1: Analysis of evidence and lessons learned (part 1), HC 898-1, The Stationery Office, London, 2013.

[21] General Medical Council/Nursing and Midwifery Council, Openness and honesty when things go wrong: the professional duty of candour, General Medical Council, Manchester, 2015.

[22] B. Burford, G. Morrow, C. Rothwell, M. Carter, J. Illing, Professionalism education should reflect reality: findings from three health professions, Med Educ. 48 (2014) 361-74.

[23] World Health Organization, WHO multi-professional patient safety curriculum guide, 2011. http://www.who.int/patientsafety/education/curriculum/Curriculum_Tools/en/ (accessed 15 November 2017).

[24] General Medical Council and Medical Schools Council, First, do no harm. Enhancing patient safety teaching in undergraduate medial education. A joint report by the General Medical Council and the Medial Schools Council, General Medical Council, Manchester, 2015.

[25] K.W. Eva, R.M. Hatala, V.R. LeBlanc, L.R. Brooks, Teaching from the clinical reasoning literature: combined reasoning strategies help novice diagnosticians overcome misleading information, Med Educ. 41 (2007) 1152-8.

[26] S. Mamede,T. van Gog, A.S. Moura, R. de Faria, J.M. Peixoto, R.M. Rikers, H.G. Schmidt, Reflection as a strategy to foster medical students' acquisition of diagnostic competence, Med Educ. 46 (2012) 464-72.

[27] M. Chamberland, S. Mamede, C. St- Onge, J. Setrakian, L. Bergeron, H. Schmidt, Self- explanation in learning clinical reasoning: the added value of examples and prompts, Med Educ. 49 (2015) 193-202.

[28] M.L. Graber, N. Franklin, R. Gordon, Diagnostic error in internal medicine, Arch Intern Med. 165 (2005) 1493-9.

[29] G.R. Norman, K.W. Eva, Diagnostic error and clinical reasoning, Med Educ. 44 (2010) 94-100.

[30] J.A. Cleland, S. Ross, S.C. Miller, R. Patey, 'There is a chain of Chinese whispers….': empirical data support the call to formally teach handover to prequalification doctors, Qual Saf Health Care. 18 (2009) 267-71.

[31] M. Gordon, R. Findley, Educational interventions to improve handover in healthcare: a systematic review, Medical Educ. 45 (2011) 1081-9.

[32] P. Duke P, R.M. Frankel, S. Reis, How to integrate the electronic health record and patient-centered communication into the medical visit: a skills-based approach, Teach Learn Med. 25 (2013) 358-65.

[33] R.H. Ellaway, L. Graves, P.S. Greene, Medical education in an electronic health record-mediated world, Med Teach. 35 (2013) 282-6.

[34] L.M. Noble, The future of the doctor-patient relationship, in: J. Brown, L.M. Noble, A. Papageorgiou, J. Kidd (Eds.), Clinical communication in medicine, John Wiley and Sons, Chichester, 2016, pp. 57-64.

[35] R. Mirezami, J. Nicholson, A. Darzi, Preparing for precision medicine. NEJM. 366 (2012) 489-91.

[36] J. Silverman, S. Kurtz, J. Draper, Skills for communicating with patients, CRC Press, Boca Raton, Florida, 2013.

[37] A. King, R.B. Hoppe, “Best practice” for patient-centered communication: a narrative review, J Grad Med Educ. 5 (2013) 385-93.

[38] J. Brown, L.M. Noble, A. Papageorgiou, J. Kidd (Eds.), Clinical communication in medicine, John Wiley and Sons, Chichester, 2016.

[39] K.A. Ericsson, Deliberate practice and the acquisition and maintenance of expert performance in medicine and related domains, Acad Med. 79 (2004) S70-81.

[40] A. Coulter, A. Collins, Making shared decision making a reality: no decision about me without me, The King’s Fund, London, 2011.

[41] G. Elwyn, M.A Durand, J. Song, J. Aarts, P.J Barr, A. Berger, N. Cochran, D. Frosch, D. Galasiński, P. Gulbrandsen, P.K. Han, A three-talk model for shared decision making: multistage consultation process, Brit Med J. 6 (2017) 359.

[42] L.M. Noble, Shared decision making, in M. Lloyd, R. Bor, L.M. Noble (Eds.), Clinical communication skills for medicine, Elsevier, Edinburgh, 2018, pp 71-85.

[43] B. O'Neill, E. Gill, P. Brown, Deaf awareness and sign language: an innovative special study module, Med Educ. 39 (2005) 519-20.

[44] Department of Health, NHS Patient Experience Framework, 2012. https://www.gov.uk/government/publications/nhs-patient-experience-framework (accessed 15 November 2017).

[45] General Medical Council, Good Medical Practice, General Medical Council, Manchester, 2013.

[46] General Medical Council, Outcomes for graduates (tomorrow's doctors), General Medical Council, Manchester, 2015.

[47] J. Brown, Behaviourism as a way of learning, in: J. Brown, L.M. Noble, A. Papageorgiou, J. Kidd (Eds.), Clinical communication in medicine, John Wiley and Sons, Chichester, 2016, pp. 181-85.

[48] W. Scott-Smith, Transformative learning and high fidelity simulation, in: J. Brown, L.M. Noble, A. Papageorgiou, J. Kidd (Eds.), Clinical communication in medicine, John Wiley and Sons, Chichester, 2016, pp. 200-5.

[49] Z. Fritz, A.M. Slowther, G.D. Perkins, Resuscitation policy should focus on the patient, not the decision. Brit Med J. 356 (2017) j813.

[50] R. Parry, V. Land, J. Seymour, How to communicate with patients about future illness progression and end of life: a systematic review, Brit Med J. Support Palliat Care 4 (2014) 331-41.

[51] B. Hanratty, E. Lowson, L. Holmes , G. Grande, A. Jacoby, S. Payne, J. Seymour, M. Whitehead, Breaking bad news sensitively: what is important to patients in their last year of life? Brit Med J. Support Palliat Care 2 (2012) 24-8.

[52] N. Dogra, F. Bhatti, C. Ertubey, M. Kelly, A. Rowlands, D. Singh, M. Turner, Teaching diversity to medical undergraduates: curriculum development, delivery and assessment, AMEE GUIDE no. 103, Med Teach. 38 (2016) 323-37.

[53] M. Turner, N. Dogra, Diversity issues in clinical communication, in: J. Brown, L.M. Noble, A. Papageorgiou, J. Kidd (Eds.), Clinical communication in medicine, John Wiley and Sons, Chichester, 2016, pp. 119-26.

[54] Government Equalities Office and Equality and Human Rights Commission, Equality Act 2010: Guidance, 2015. <https://www.gov.uk/guidance/equality-act-2010-guidance> (accessed 15 November 2017).

[55] S. Peters, L. Bird, H. Ashraf, S. Ahmed, P. McNamee, C. Ng, J. Hart, Medical undergraduates' use of behaviour change talk: the example of facilitating weight management, BMC Medical Education, 13 (2013) 7.

[56] Public Health England, Making every contact count (MECC): consensus statement, Public Health England, London, 2016.

[57] K. Joekes, J. Brown, K. Boardman, L. Tincknell, D. Evans, A. Spatz, Hybrid simulation for integrated skills teaching, International Journal of Clinical Skills.10 (2016) 1-5.

[58] J. Brown, Perspective: clinical communication education in the United Kingdom: some fresh insights, Acad Med. 87 (2012) 1101-4.

[59] H.S. Wald, P. George, S.P. Reis, J.S.Taylor, Electronic health record training in undergraduate medical education: bridging theory to practice with curricula for empowering patient-and relationship-centered care in the computerized setting, Acad Med. 89 (2014) 380-6.

[60] D. Swinglehurst, T. Greenhalgh, C. Roberts, Computer templates in chronic disease management: ethnographic case study in general practice, Brit Med J Open. 2 (2012) e001754.

[61] J. Noordman, P. Verhaak, I. van Beljouw, S. van Dulmen, Consulting room computers and their effect on general practitioner–patient communication, Fam Pract. 27(2010) 644-51.

[62] J. Thistlethwaite, Interprofessional education: a review of context, learning and the research agenda, Med Educ. 46 (2012) 58-70.

[63] P. Maguire, C. Pitceathly, Key communication skills and how to acquire them. Brit Med J. 325 (2002) 697-700.

[64] R.L. Hulsman, W.J. Ros, J.A. Winnubst, J.M. Bensing, Teaching clinically experienced physicians communication skills. A review of evaluation studies. Med Educ. 33 (1999) 655-68.

[65] K. Aspegren, BEME Guide No. 2: Teaching and learning communication skills in medicine: a review with quality grading of articles, Med Teach. 21 (1999) 563-70.

[66] S. Kurtz, J. Silverman, J. Draper, Teaching and learning communication skills in medicine, 2nd edition, CRC Press, Boca Raton, Fl, 2004.

[67] D. Newble, Revisiting 'The effect of assessments and examinations on the learning of medical students', Med Educ. 50 (2016) 498-501.

Figure 1

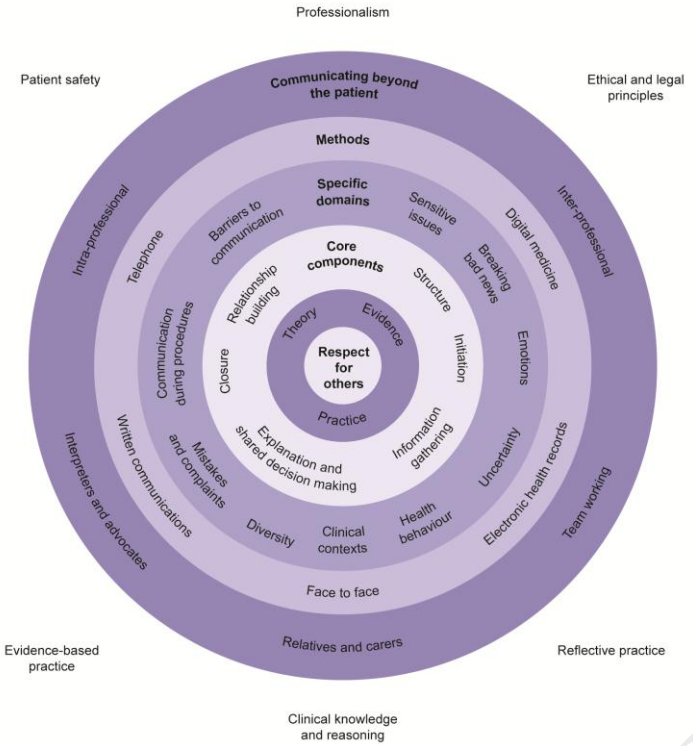

Table 1. What patients want from communication with their doctor [18]

Greeted me in a way that makes me feel comfortable			
Treated me with respect			
Showed interest in my ideas about my health			
Understood my main health concerns			
Paid attention to me (looked at me, listened carefully)			
Let me talk without interruptions			
Gave me as much information as I want			
Talked in terms I could understand			
Checked to be sure I understood everything			
Encouraged me to ask questions			
Involved me in decisions as much as I want			
Discussed next steps, including any follow-up plans			
Showed care and concern			
Spent the right amount of time with me			